



Aetna

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☒ (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) W688264592																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Foster, Emma										3. PATIENT'S BIRTH DATE MM DD YY 03 07 1983 SEX M ☐ F ☐										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Foster, Emma																																							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State) c. OTHER ACCIDENT? ☐ YES ☒ NO 10d. CLAIM CODES (Designated by NUCC)										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Aetna Plan d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE QUAL MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? \$ CHARGES ☐ YES ☐ NO																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. K219 B. C. D. E. F. G. H. I. J. K. L. ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																																											
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25. FEDERAL TAX I.D. NUMBER SSN EIN 84-2210094 X										26. PATIENT'S ACCOUNT NO. pat-gen-203										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO										28. TOTAL CHARGE \$ 230.00										29. AMOUNT PAID \$ 15.18										30. Rsvd. for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File										32. SERVICE FACILITY LOCATION INFORMATION Northstar Family Health - Main 1420 Birchwood Ave Portland, OR 97214										33. BILLING PROVIDER INFO & PH # () Northstar Family Health																																							
SIGNED DATE										a. 1982744321 b.										a. 1982744321 b.																																							